Roadmap to the Patient-Centered Medical Home

PRESENTED TO:
TENNESSEE MEDICAL ASSOCIATION

presented by:
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Introduction
What is PCMH?

Patient-Centered Medical Home

- A model of primary care that improves clinical quality, lowers costs, and improves patient satisfaction through care coordination.
- First program through NCQA started in 2003. Standards have evolved over the years to be consistent with Meaningful Use and other meaningful quality metrics.
PCMH 2014 Standards

PCMH 1: Patient-Centered Access
PCMH 2: Team-Based Care
PCMH 3: Population Health Management
PCMH 4: Care Management and Support
PCMH 5: Care Coordination and Care Transitions
PCMH 6: Performance Measurement and Quality Improvement
PCMH 2014 “Must Pass”
Elements for Certification

1A: Patient-Centered appointment access
2D: The practice team (team-based care)
3D: Use data for population management
4B: Care planning and self-support
5B: Referral tracking and follow up
6D: Implement continuous quality improvement
Requirements to Achieve Patient-Centered Medical Home Recognition

- “All or nothing” physician participation
- Site-specific
  - Single site (1-2 locations) versus multiple sites
- Levels:
  - I: 35-59 points
  - II: 60-84 points
  - III: 85-100 points
- Must Pass Elements/Critical Factors
PCMH Facts

- PCMH 2011 and 2014 are closely aligned with Meaningful Use reporting requirements.
- Practices are not required to have a certified EMR (though a requirement for chronic care management).
- Each practice location is certified versus each clinician. Clinicians are certified by way of their practice location.
- Practices must report on 12 months of data. If the practice EMR has not been in place for 12 months, NCQA will accept three months of data.
- Calendar year reporting is not required.
PCMH Facts

PCMH identifies primary care providers practicing at each site, including nurse practitioners and physicians assistants, that can be designated as a patient’s personal clinician (with their own panel of patients). New providers are certified upon becoming employed by a certified practice.

Practices may add and remove clinicians for the duration of their recognition.
Required Documentation

- Documented processes: written procedures, processes, and workflow forms (not explanations). These should show the practice name and date of implementation.

- Reports: Aggregated data showing evidence related to specific factors

- Records or files: Patient files or registry entities documenting actions taken; data from medical records

- Materials: Information for patients or clinicians, clinical guidelines, self-management, and educational resources
Why PCMH?
Benefits of PCMH

- Increased care quality/decreased liability
- Increased patient satisfaction
- Reduced physician burnout
- Reduced hospitalization rates
- Decreased cost of patient care

Source: NCQA, 2013
Benefits of PCMH

- Additional revenue
  - Positive patient feedback and referrals
  - Increased payer reimbursement
  - More physician availability to see patients

- Readiness for value-based reimbursement, participation with ACO, chronic care management ($40.39 PMPM), transitional care management ($164-$231).

Source: NCQA, 2013
Financial and Operational Considerations
Extended Office Hours

- Improved access and convenience for patients
  - Same day appointments
  - Availability beyond regular business hours (e.g., early mornings, evenings, weekends)

- Clinical advice by telephone and electronic means
Updated IT Solutions

- Necessary to improve collection, storage, and management of electronic health information
- Tracking improvement in processes and patient outcomes
- Better communication among providers
- Patient accessibility to health information
- Patient self-management tools
- e-Prescribing
Staffing

- May require an increase in staff to improve workflow
- Diverse backgrounds to appropriately address cultural and linguistic needs of patient population
- May require staff with more training (LPN, RN)-especially in the clinical area to effectively assist the patients
- Training in evidence-based approaches to patient self-management, population management, and patient communication
- Effective management of staff
Physician Workflow Changes

- Implementation of new policies and procedures
  - Pre-visit preparations/team coordination
  - Written care plans
  - Follow-up
  - Medication management; e-Prescribing
- Documentation requirements
- Coordination of referrals
Patient Satisfaction Tools

- Track and measure performance
  - Qualitative and quantitative methods

- Obtain patient feedback
  - Focus groups
  - Patient satisfaction survey
  - CAHPS PCMH survey tool
Operationalize PCMH
Quality Care Implementation
Quality

Practice should consider policies and strategies for:

- Structured communication between the clinician and other care team members.
- Educating patients on illnesses and treatment options.
- Identifying patients with certain conditions and monitoring improvement and/or compliance with recommended treatment.
- Follow-up to include newborn hearing tests, lab results, imaging results, and referrals.
- Notifying families of normal and abnormal results.
Access
Elements of Access

Access

- Scheduling same-day appointments.
- Arranging appointments for alternative types of encounters such as telephone, video chat visits.
- Defining the practice’s standards for timely appointment availability.
- Monitoring scheduled visits. Practice should track no-shows.
- Providing timely clinical advice to patients by telephone, whether the office is open or closed.
- Assess current appointment availability.
- Determine if provider staffing is adequate. Would a mid-level be helpful?
- Evaluate no show rate and determine the cause (wait, patient resources, etc.). Implement and enforce no show policy.
- Assess quality of current call coverage arrangements. Revise as needed.
- Evaluate after hour patient record access options.
Transitional Care Management
Elements of Transitional Care Management ("TCM")

**TCM**

- Identifying patients who have been hospitalized or have had an ER visit
- Providing hospitals and ER with clinical information
- Patient follow-up after a hospital admission or ER visit
- Obtaining hospital discharge summaries
- Two-way communication with hospitals
- Obtaining proper consent for release of information and transition care plans

**CPT codes 99495 and 99496**
Non-Face-to-Face Services

- Obtain and review discharge information.
- Review need for, or follow-up on, pending diagnostic tests and treatments.
- Interact with other providers involved in patients care.
- Educate patient, family, guardian, and/or caregiver.
- Arrange for needed community resources.
Practice Plan for Implementation

- Assign staff to review hospital admission log on a daily basis.
- Inform nurse/provider of patient admission.
- Specify timeline for follow-up after notification (by end of day, next day, within two days, etc.).
- Evaluate community and referral resources.
- Train staff on documentation.
- Spot review discharge report and documentation of follow-up on a monthly basis for compliance.
- Continue training.
Referral and Test Tracking
Elements of Referral Tracking

Referral Tracking

- Providing the consulting clinician or specialist the clinical question, required timing, and other important information.
- Providing the consulting clinician or specialist pertinent demographic and clinical data, including test results and the current care plan.
- Tracking referrals until the consulting clinician’s or specialist’s report is available, flagging and following up on overdue reports.
- Asking patients/families about self-referrals and requesting reports from clinicians.
Elements of Test Tracking

- Follow up on newborn hearing tests and blood-spot screening
- Tracking lab tests until results are available
- Tracking imaging tests until results are available
- Flagging abnormal lab results and bringing to the attention of the clinician
- Flagging abnormal imaging results and bringing to the attention of the clinician
- Notifying patients/families of normal and abnormal lab and imaging test results
Practice Plan for Implementation

- Assign staff responsibility and train.
  - Train individuals on normal response times and expected follow-up timeframes.
  - Advise staff of medical record transfer procedures.
  - Train providers/clinical staff on complete referral documentation requirements.
  - Define timeline and process for follow-up with patients regarding referral appointments.
  - Define timeline and process for follow-up with specialists regarding report.
Practice Plan for Implementation

- Monitor compliance with test tracking and referral follow-up.
- Provide additional training as necessary.
- Hold staff accountable.
Pre-Visit Planning
Pre-visit Planning

- Coordinate with clinical team to review important information prior to patient appointments.
- Review/Discuss:
  - Patient referral appointments.
  - Important behavioral or socioeconomic conditions.
  - Lab/test results.
- Pre-planning meeting should be no longer than 15 minutes.
Practice Plan for Implementation

Staff must be in compliance with referral and test follow-up.

Print appointment schedule at least one day in advance.

Clinical staff should make important notes for physician’s review.

Providers should offer feedback regarding ways to enhance pre-planning.
Population/Chronic Condition Management
Population Management

Practice should provide identify patients in the following categories:

- Behavioral health conditions.
- High Cost/High Utilization (multiple emergency room visits (“ER”), hospital readmissions, high number of prescriptions, etc.).
- Poorly controlled conditions (asthma, diabetes, etc.).
- Social determinants of health (availability of resources, exposure to poor environments, etc.).
Elements of Chronic Care Management ("CCM")

- Identifying patients who have two or more chronic conditions expected to persist at least 12 months that place the individual at significant risk of death
- Use of certified EHR
- Patient consent
- Provision of care plan
- 24/7 access to the care team
- Provision of transitional care management services
- Coordination with service providers to meet the patient’s psychosocial needs

CPT code 99490
Practice Plan for Implementation

- Compile appropriate resources (literature, referral sources, self-care support tools, etc.).
- Provide staff training on conditions as necessary.
- Continuously monitor patient population for new conditions.
- Review patient status for improvement.
- Revise procedures and tools as necessary to aid continuous improvement.
Other Considerations
Staffing and Workflow
Staffing Considerations

- **LPN/RN**
  - Patient communication/counseling, population health management

- **Referral coordinator**
  - Transitional care, specialist referral, community resource referral

- **Quality coordinator (IT competence)**
  - Manage patient data, compile results, monitor documentation requirements
Action Plan
Action Plan

- Assess current operations.
- Train staff on operational procedures and plan monthly in-service or updates on revised operations.
- Evaluate options for implementing each functional area (personnel task list).
  - Utilize IT
  - Revise staff roles
  - Additional staff

SUCCESS AHEAD
Action Plan

- Communicate with providers for staffing and workflow preferences
- Create new policies (or revise current)
- Train individual staff on their new roles
- Train each department on the effect of revised roles
- Continuously monitor progress and effectiveness
How Can PYA Assist

- PCMH Certification Content Expert (PCMH CCE)
- GAP analysis tool for PCMH and CCM
- Consult to assess current operations and identify opportunities and barriers
- Detailed workplan for transformation and ongoing monitoring of progress
- Staff training
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